### DECISIONS EVERY PHYSICIAN SHOULD MAKE

Every physician should decide which of the following systems he wants:

1. A completely federalized system for all Americans with part of the puppet strings pulled by the United States Public Health Service and part by a lay Social Security Board.

2. A system owned, financed and operated by industry which may rise and fall with Dow-Jones averages.

3. A system directed and guided by physicians, including county or federal care for the indigent, applying the prepaid principle to the lower brackets and allowing the doctor to charge a private fee to others.

4. A system directed and guided by commercial insurance companies, or

5. A system that remains *status quo* and sings its theme song of "stand-patism."

I should like to make the following recommendations, to which I claim no originality:

### RECOMMENDATIONS: IN RELATION TO NATIONAL NEEDS

1. A full-time resident representative with diplomatic experience in Washington.

2. Whole-hearted coöperation with the United States Public Health Service.

3. Whole-hearted coöperation of the American Hospital Association and the American Medical Association.

4. A definite stand by the American Medical Association for prepaid health insurance on a voluntary basis.

5. Establishment of a Medical Service Plan Commission within the American Medical Association to collect and pool the experience of the constituent state societies regarding prepaid medical service.

6. Employment of more full-time personnel for study of voluntary health insurance with reëstablishment and expansion of the Bureau of Medical Economics.

7. A public relations program which will win back for the physicians as a whole greater respect from the public and which will change the opinion toward the American Medical Association from that of a monopolistic body to one of guardianship and trusteeship of America's most sacred need—medical care.

8. A review of the studies of the Committee on the Costs of Medical Care in the light of the Wagner bill.

9. Expenditure of as much time in studying methods of distribution of medical care as we have spent in the improvement of medical care.

### RECOMMENDATIONS: IN RELATION TO CALIFORNIA'S NEEDS

1. Formation of a state-wide nonprofit hospital service plan in accordance with the recommendations of the Mannix survey.

2. Stimulation of greater interest on the part of the physician in California Physicians' Service.

3. Amalgamation of administrative and enrollment programs for the state-wide hospital and medical service plans.

4. Continuation of the coöperation which now exists between the California Medical Association and the California State Department of Public Health.

5. Coöperation of physicians and hospitals with the Procurement and Assignment Service of the War Manpower Commission and other governmental agencies in the prosecution of the war.

6. Continuation of interest and study in the methods of distributing medical care in California.

Lane Hospital, Clay and Webster Streets.

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## MEDICAL PRACTICE: ITS EVOLUTION*

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DURING the three years following World War I, more people died from famine and preventable disease than lost their lives in the War itself. Already a half-dozen uncoördinated agencies of the Federal Government are dealing with the various phases of the problems related to health that are likely to become prominent in the postwar period.

The building of hospitals, the redistribution of physicians, the prevention of disease, the promotion of health, the development of health centers, the determination of nutritional deficiencies, the rehabilitation of medical material and equipment, and the distribution of trained scientific personnel, are among the activities related to health which demand study and for which there must be planning. Even now a half-dozen governmental agencies are actually competing with one another for the available medical personnel and the available medical supplies. In the postwar period such competition, under uncontrolled conditions, might well be ruinous.

If there is one need outstanding at this time it is the establishment of an overall governmental agency to which would come the demands for medical personnel, medical supplies, hospitals and hospital equipment or other medical needs. From such an agency allocation or recommendations might be made on the basis of exact knowledge or inventory such as is now kept by the Procurement and Assignment Service for Physicians as to the availability of physicians, and by the War Production Board as to the availability of materials. Such an agency would equally be in a position to advise the President, the Congress, or the individual bureaus of the Federal Government as to medical necessities and the possibilities of meeting the existing needs. From the very nature of its work such an agency would include in its member-

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* From the office of the editor of *The Journal of the American Medical Association* and *Hygiea*.
Abstract of one of the addresses in a symposium given at the 75th Anniversary, San Francisco County Medical Society, November 7, 1943.

ship not only the medical profession, but leaders in the fields of public health, education, and the production of medical materials.

### ACHIEVEMENTS OF AMERICAN MEDICINE

The progress of medicine in the United States has been one of the phenomena of the last century. Today the world as a whole recognizes the achievements of American medicine. Only last week there came from Great Britain, in a letter from the British Council, one of the most important planning organizations in that country, a recognition of American leadership in scientific medical bibliography and librarianship. N. Howard Jones, director of the Medical Department of the British Council, spoke of "the considerable respect that many of us here have not only for American medical literature, but for the remarkable lead that America has given to the rest of the world in everything pertaining to medical bibliography and medical librarianship."

The standards of medical education in the United States have been steadily raised since 1905, so that today the medical colleges of our country are not only on a par with, but probably superior, to most institutions devoted to medical education elsewhere in the world. Our hospitals as a group have also become noted for the quality of the service that they render.

The health of the nation as a whole is indicated by the continuously decreasing rates for death and for illness, so that in 1942 both the death rate and the morbidity rate of the nation were the lowest in our history. It may be too much to claim that this superiority is the result of the basic principles that prevail in the organization of public health and medical practice in this country. It would be the height of folly to insist that they could be wholly separated from the organization of the medical profession, the system that underlies the organization of public health administration, and the basic principles of medical practice formulated in the Principles of Ethics of the American Medical Association.

### EVOLUTION OF MEDICAL SERVICE

Since the establishment of the American Medical Association in 1847, almost one hundred years ago, the methods of administration and distribution of medical service have been undergoing continuous evolution, coördinated with the continuous advancement of medical science. Whenever a new discovery has been made for the prevention or treatment of disease, it has been incorporated into medical practice and into public health procedure. Thus, improvements in anesthesia, in the use of the x-ray, in laboratory techniques for diagnosis, in inoculation against infectious disease, in the administration of oxygen, of the sulfonamides or penicillin, or insulin for diabetes, are promptly reflected in medical practice.

True, there is a lag between the development of a technique or method and the time when it becomes the property of all physicians. Yet even this lag is, in the United States, far shorter than similar lags elsewhere in the world.

The evolution that has gone forward has taken on increased intensity since the end of World War I. Those who have participated in the advance of medicine for thirty years, as I have, know that proposals to revolutionize the nature of medical practice of the United States began to be made seriously in 1911 and 1912 when Great Britain adopted its system of compulsory sickness insurance. It will be remembered that the British medical profession resisted to its utmost the establishment of compulsory sickness insurance by the Lloyd George government, and that it failed to prevent the enactment of the British National Insurance Act. However, that Act has been, since that time, limited largely in its effects to persons with incomes under $1,200 per family per year, for whom it provides only general practitioner service such as the doctor may render in his office or in his home. It does not cover dependents, nor does it cover specialistic or hospital service.

Almost every year during the last thirty there has been introduced into the Congress of the United States legislation which would tend to compulsory sickness insurance for the American people, either in part or as a whole. Such legislation has failed of enactment. When the Social Security Act became effective in 1934, an attempt was made to include compulsory sickness insurance as the third arm of security, but at that time compulsory sickness insurance was eliminated, and funds were greatly increased for work in the field of preventive medicine under the United States Public Health Service and the Bureau of Maternal and Infant Welfare of the United States Department of Labor.

Subsequently, in 1937, a National Health Conference was held and Senator Wagner of New York introduced Bill No. 1620, which would have provided a nation-wide system of compulsory sickness insurance. Hearings were held on that proposal before the Senate Subcommittee on Education and Labor, under Senator Murray of Montana, and that proposal died when the Congress which would have considered it ceased to function.

Now comes a new proposal to expand the Social Security Act. This includes as one of its provisions a section which would put the American people under a compulsory sickness insurance provision and which would indeed place all of medicine under the Surgeon-General of the United States Public Health Service. Such a proposal, embodied in the so-called Wagner-Murray-Dingell bill, would be in every sense of the word, revolutionary.

Medicine never hesitates to use radical measures when required in a desperate situation. However, there is no evidence that the health of the people of the United States is at this time in any way in a desperate situation. Indeed, every phase of medical development in this country testifies to the soundness of the progress that has been made and indicates the desirability of continued evolution rather than revolution.

Especially serious among the proposals of the Wagner-Murray-Dingell bill is that portion which would give to a federal agency complete control

of medical education. Should that activity become effective, the Surgeon-General of the United States Public Health Service would make grants-in-aid to such institutions as he thinks "show promise of making valuable contributions to the education or training of persons useful to or needed in the furnishing of medical, hospital, disability, rehabilitation, and related benefits provided under this Act or to human knowledge with respect to the cause, prevention, mitigation, or methods of diagnosis and treatment of disease and disability."

Such political control of medical education would inevitably destroy the standards of excellence that now characterize the medical schools in America. How long would it be before the selection of medical students would become the function of political influence rather than the voluntary standards of today, which depend on methods of selecting students with regard to high personal qualifications and ethical integrity of the medical profession?

Indeed, a careful study of the Wagner-Murray-Dingell bill shows that its drafters focused their attention much more on the political machine for controlling and distributing medical service than they did on the quality of the service itself. Medical care is a service given by physicians. The ability to diagnose and treat disease and to protect the health of the public depends on the qualifications of the physician—on his education and training, his integrity, his skill, and his initiative. With such qualities the Wagner-Murray-Dingell bill is little concerned.

In the United States, during the past fifteen years the private practice of medicine has been supplemented and in many places substituted by new techniques for providing medical care. Already some thirteen millions of people are covered by insurance against the costs of hospitalization through the so-called Blue Cross plans, industrial group insurance, fraternal hospital insurance, and in other ways. Many large industries have provided systems of complete medical care for their employees. Still more arrange to meet the costs of catastrophic surgical and medical conditions.

Under these plans the patient may utilize the service of his own doctor or a specialist selected by his doctor, or of groups of physicians organized in a variety of ways. The groups of doctors who render service are sometimes organized as employees of a corporation, sometimes as partners in a corporation, sometimes as the employees of educational institutions.

There are plans for distribution of medical service under prepayment techniques organized by various communities, by farm groups, by governmental agencies, and by industries. Most of these plans differ today from what they were when they were first organized. They are still undergoing active evolution.

There is much misunderstanding of the relationship of the American Medical Association to these proposals. The American Medical Association has accepted the principle of insurance against the hazards and costs of sickness. However, medical leadership does not encourage politics in medical care and is, in general, inclined to local rather than federal control.

Notwithstanding much that has been said to the contrary, there has never been opposition to the practice of medicine by groups of physicians. There has been opposition to certain methods used by such groups which tend to deteriorate the quality of the service and make the cost in fees considerable. Underbidding by groups of physicians for the medical care of employees of certain industries, house-to-house solicitation of patients and similar practices are fought by the medical profession, not with a view to protecting the physician or his fee for service, but primarily because such practices lead to deterioration in the nature of medical service that is rendered.

When assumption *B* of the Beveridge plan was placed before the British Medical Association by the Ministry of Health, arrangements were made to summon the representative committees of that body and for them to present their recommendations to the representative body of the British Medical Association, which is similar to our House of Delegates. That representative body has just concluded a series of principles underlying the plan by which medical service would evolve in Great Britain. The basic principles are essentially the same as those which were adopted as the platform of the American Medical Association several years ago. Moreover, the secretary of the British Medical Association has recently published his views, and has used as the title for his address the slogan that we submitted in 1932, *"Evolution not Revolution."*

In several of its proposals the British Medical Association states the philosophy of health service so clearly that they cannot be improved on. Thus, they emphasize the importance of preventive medicine, the desirability that the general practitioner be the mainstay in medical service, that laboratory facilities and consultants be available, and that there be coördination between the various agencies concerned with medical care.

Then they say: "The health of the people depends primarily upon the social and environmental conditions under which they live and work, upon security against fear and want, upon nutritional standards, upon educational facilities, and upon the facilities for exercise and leisure. The improvement and extension of measures to satisfy these needs should precede or accompany any future organization of medical services.

"The efficiency of a country's medical services, both preventive and curative, depends upon the available medical and scientific knowledge, upon the character and extent of medical education, upon the sufficiency and quality of personnel, upon facilities for treatment and upon the absence of any economic barriers that impede the utilization of such services. Thus, in order to improve the country's medical services, the facilities and resources for medical research should be greatly increased and methods devised for their adequate application; medical education, both undergraduate and post-

graduate, should be maintained on a high standard and be adapted to modern needs; there should be sufficiency of personnel and institutional accommodation; and wherever economic barriers prevent an individual taking advantage of medical services such barriers should be removed."

Next, the representative body stated that the functions of the state should be to coördinate existing provision, to augment it where necessary, and control economic barriers to good medical service.

The platform of the American Medical Association calls for:

"The establishment of an agency of federal government under which shall be coördinated and administered all medical and health functions of the Federal Government exclusive of those of the Army and Navy.

"The allotment of such funds as the Congress can make available to any state in actual need for the prevention of disease, the promotion of health and the care of the sick on proof of such need."

Indeed, the American Medical Association has heartily approved the provision of medical care for the indigent and the medically indigent with determination of need, and local control of administration.

This proposal for utilization of federal funds is far different from the erection of a federal mechanism involving the expenditure of $4,000,000,000 annually, such as is proposed in the Wagner-Murray-Dingell bill.

The American Medical Association has proposed as the seventh tenet in its platform:

"The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability."

The representative body of the British Medical Association has said that it is not in the public interest that the state should convert the medical profession into a salaried branch of central or local government service; that it is not in the public interest that the state should invade the doctor-patient relationship, and, finally, there should be initiated, by arrangement and agreement between the government and the profession, organized experiments in the methods of practice, such as group practice, including health centers of different kinds which should extend to general practitioner hospital units attached to general hospitals. Future developments in group practice should depend upon the results of such clinical and administrative experimentation.

Thus, without the slightest consultation or interchange of opinion other than appears in the medical press of the two nations, the British medical profession and ours are in agreement as to the trend which the evolution of medical practice should follow.

We, in this country, have already begun many experiments with and without the aid of the Government. Mr. Henry Kaiser's industrial plan is evidence of the manner in which experimentation may be undertaken, but time alone can indicate the evolution which that plan will follow to meet changing economic situations. Even the kind of group practice utilized by the Mayo, Lahey, and Crile Clinics, not to mention the Shadid and Ross-Loos Clinics, undergoes constant changing. It would be folly to offer any one of these experiments in the light of present conditions as the system to be followed by the entire nation.

No doubt, the plan utilized by the Farm Security Administration for giving medical care to 105,000 farm families has virtues, but even that plan has been modified from county to county, and from state to state.

Many a great organization, such as Sears-Roebuck, Western Electric Company, Endicott-Johnson Shoe Company, and, indeed, the headquarters of the American Medical Association, utilizes the services of the well-established insurance companies like the Metropolitan, New York Life, Travelers', Aetna, etc., to provide hospitalization, or sickness, or catastrophic insurance for its employees.

Fourteen state medical societies have erected plans whereby such organizations coöperate in extending hospitalization and sickness insurance to groups of workers who care to coöperate.

Medicine has not been static, neither has there been discouragement from professional medicine beyond what is needed to protect the public against those who see in the administration of medical service an unusual opportunity for exploitation because of appeal to a man in his time of greatest need.

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## OBSERVATIONS OF A MEDICAL OFFICER IN THE SOUTH PACIFIC AREA*

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FOREWORD.—In the spring of 1942 I was ordered to report to a West Coast port of embarkation for overseas duty. I was placed in command of a Medical Unit with a large staff of medical officers, dental officers, nurses, and trained enlisted medical technicians. We sailed to an unknown destination. By the end of the first day out many of the staff were seasick and so did not enjoy any part of the voyage. Day after day we zigzagged across the broad Pacific, and as the temperature went higher and higher we decided we were headed for some place in the South Pacific area.

Old King Neptune held his royal court aboard ship the day we crossed the Equator, and the very amusing ceremonies incident to making us all "shell-

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* Read before the annual meeting of the Oregon State Medical Society, Portland, Oregon, September 4-5, 1943.

The opinions and assertions contained herein are the private ones of the writer and are not to be used as official or reflecting the view of the Army Department or the Army service at large.

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